



Risks Of Claims-Made Insurance

A seemingly less-expensive liability insurance option may contain onerous hidden costs.

IN THE WAKE OF THE LIABILITY insurance crisis in long term care, some insurance companies are offering seemingly less expensive coverage by writing “claims-based” policies, which differ in significant ways from traditional “occurrence-based” policies. The differences between these insurance products could well determine whether an incident that leads to a legal action against a provider is ultimately covered or not covered under the policy. Also, while a claims-made policy sometimes may appear less expensive than an occurrence-based policy, there may be substantial hidden costs.

How The Claims-Made Policy Works

Historically, liability coverage for long term care facilities has been offered on an occurrence basis. This means that the claim “trigger”—the date on which a liability claim is considered activated—is the same as the date on which the alleged injury occurred. From a policy-coverage perspective, it does not matter when the claim is reported to the insurance company, provided it falls within the statute of limitations.

Under a claims-made form, however, the coverage trigger is not the date of the occurrence, but the date the claim is reported to the insurance company—often a year or more after the actual date of the occurrence. Claims-made policies typically cost only 50 to 80 percent as much as occurrence policies for first-year premiums.

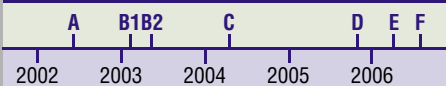
But before taking these savings to the bank, providers must ask themselves two key questions: 1.) How will

the claims-made policy impact coverage; and 2.) What does a provider need to consider when faced with a claims-made coverage option?

To answer both of these questions, it is important to first understand the timeline of events that may occur between an alleged negligent act and the eventual payment of a claim under a liability insurance policy.

The timeline below assumes that point A represents a patient who falls, resulting in an injury in April 2002. This incident is reported, and the

TIMELINE—FROM AN INCIDENT TO A PAID LIABILITY CLAIM



patient’s family is promptly notified. Then, in February 2003 (point B1), the facility receives a letter from an attorney requesting the patient’s medical records. Within a very short period after this request (point B2), the facility notifies its insurer that a claim is imminent. In March 2004 (point C), a lawsuit alleging professional negligence is filed against the facility (within the state’s two-year statute of limitations). Depositions and other legal processes take place between points C and D. The suit is finally set for a trial in June 2006 (point F), but is then settled out of court in April 2006 (point E).

This timeline illustrates a four-year span between the alleged patient injury incident and the paid claim. During that time period, the provider’s insurance company may have posted a wide

variety of reserves for what it believed would be the ultimate pay-out. In this case, for example, the claim might have been initiated with a \$10,000 reserve, raised a year or two later to \$250,000, and eventually might have settled for less than \$100,000. During this time, the insurance company has attempted to estimate ultimate claim cost, although the potential margin of error is quite broad.

Since the timeline of events can be several years and estimating a claims settlement is not a perfect science, insurance companies would prefer to limit the amount of time they are obligated to pay claims. The claims-made coverage form is one way to do this. Under a claims-made policy, the trigger in the sample timeline occurs when the claim is reported to the insurance company (B2), a full year after the actual occurrence.

If the initial policy was an occurrence-based policy with an effective date of Jan. 1, 2002, and an expiration date of Jan. 1, 2003, the initial policy limits and terms would apply to the claim that eventually was settled and paid out in 2006. Under this occurrence policy scenario, it is not important that the claim was reported to the insurance company during the subsequent policy period. Again, the focal point determining the coverage trigger is the date the incident or injury occurred.

If the initial policy was a first-year,

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Frequently Asked Questions On Claims-Made Coverage

Q: Should claims-made coverage be viewed as a way for an insured provider to save money?

A: Generally not. While the initial premium for a claims-made policy might appear cheaper than an occurrence policy, it may well prove costlier in the long run due to extended reporting-period premiums.

Q: How much does an ERP cost?

A: It depends upon the state and the company, but the premium for ERPs generally ranges from 100 to 300 percent of the expiring annual premium. Some states allow for an underwriting process to determine the cost, while others mandate that all insured parties receive the same percentage.

Q: Does an ERP establish an additional (reinstated) policy aggregate limit?

A: Some do. However, most surplus lines programs do not provide a sup-

plemental aggregate limit in addition to the initial policy aggregate limit. In this event, all claims under the ERP would fall within the original policy limit.

Q: Do ERPs allow for indefinite reporting of claims (assuming the occurrence was after the retroactive date and before the end of the policy period)?

A: Not usually. Most programs do not provide coverage after three years past the expiration date.

Q: What does an insured party need to consider if it wants to switch from a claims-made to an occurrence policy?

A: The most significant issue is coverage for claims that occurred during the claims-made policy period but that are reported after the claims-made policy period. Under these circumstances, the insured party would need to purchase an ERP from the expiring carrier.

is essential that any insured providers contemplating claims-made coverage ask their agents, consultants, or attorneys to explain the implications in detail.

Another very important discussion point is the purchase of an “extended reporting period” (ERP). The ERP can be purchased by an insured provider whose policy has been canceled or not renewed or who simply decides to work with another insurance company. It provides an additional period of time for which claims can be reported under the expiring claims-made policy. But the pricing of this option can be tricky.

An illustration representing a long

term care operation that was fortunate enough to receive both claims-made and occurrence quotes can be found at the bottom of this page.

In this illustration, the claims-made option appears to be \$35,000 less than the occurrence option. However, there are significant financial risks. If the insurance company offering Option II decides not to renew the policy, the insured may purchase the ERP, but it will probably cost 150 to 200 percent of the expiring premium. If 150 percent was the factor, the ultimate cost for the policy term would be \$162,500 (\$65,000 original premium + \$97,500 ERP premium), or \$62,500 higher than the occurrence option. If the ERP factor was 200 percent, the ultimate cost for that policy term would be \$195,000 (\$65,000 original premium plus \$130,000 ERP premium), or \$95,000 more than the occurrence option. In either case, the insured would end up paying significantly more for claims-made coverage than for an occurrence policy.

Further aggravating this financial situation is the fact that the costs for the ERP might be incurred in the same fiscal year as the premium for the next policy period. If a provider went with the claims-made program and had to change insurance companies or programs the second year, premium expenses might look like this:

■ *Fiscal year 2002*—\$65,000 (the cost of the claims-made policy in Option II).

■ *Fiscal year 2003*—\$182,000 (\$84,500 for new claims-made program at approximately 30 percent rate increase + \$97,500 for ERP from previous claims-made program). ■

The issues of a claims-made policy can become very complex if the provider changes insurers, especially if subsequent insurance companies do not agree to accept claims with occurrence dates prior to their effective dates. When changing insurers, therefore, providers must pay close attention to the new policy’s “retroactive date,” which is distinct from the policy’s effective and expiration dates. The retroactive date is the earliest date that an incident or injury could have occurred and still potentially be covered under the claims-made policy. It

OCCURRENCE VS. CLAIMS-BASED COVERAGE—ANNUAL PREMIUM COST ANALYSIS

Option I: Occurrence	Option II: Claims-Made (retroactive date 11/01/02)
Policy term: 11/01/2002—11/01/2003	Policy term: 11/01/2002—11/01/2003
Annual premium: \$100,000	Annual premium: \$65,000
ERP: Does not apply	ERP: Up to 200% of the annual claims-made premium due within 60 days of 11/01/2003 (potential cost: \$130,000)